89-1048

No. ________

In The

Supreme Court of the United States

October Term, 1989

FMC CORPORATION,

Petitioner,

v.

CYNTHIA ANN HOLLIDAY,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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QUESTION PRESENTED

Whether ERISA's express preemption provisions, as interpreted in *Metropolitan Life v. Massachusetts*, prohibit states from applying state insurance regulations to self-funded employee welfare benefit plans, as to which the courts of appeals are in conflict?

PARTIES TO THE PROCEEDINGS

Petitioner, FMC Corporation, is a Delaware corporation with its principal place of business in Illinois. FMC's subsidiaries include: FMC do Brasil S.A., FMC Mid-Atlantic Investments Limited, Mid-Atlantic Acceptance Company Limited, FMC Gold Company, FMC Paradise Peak Corporation, FMC Jerritt Canyon Corporation, FMC International, A.G., FMC Wyoming Corporation, Foret, S.A., Lithium Corporation of America. Respondent, Cynthia Ann Holliday, is an individual and citizen of Pennsylvania.

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PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

The Petitioner, FMC Corporation ("FMC"), respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Third Circuit, entered in the above-entitled proceeding on September 11, 1989.

OPINIONS BELOW

The district court's opinion (C1) is not officially reported. The opinion of the United States Court of Appeals for the Third Circuit is reported at 885 F.2d 79 (3d Cir. 1989). (A1)

JURISDICTION

The Court of Appeals entered its opinion and judgment in this case on September 11, 1989. (A1) FMC's Motion for Rehearing *En Banc*, filed on September 21, 1989, was denied by the Court of Appeals on October 5, 1989. (B1)

The jurisdiction of this Court to review the decision of the Court of Appeals is invoked under 28 U.S.C. §1254(1).

STATUTES INVOLVED

Section 514(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), provides:

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

29 U.S.C. §1144(a).

Section 514(b)(2)(A) of ERISA provides:

Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

29 U.S.C. §1144(b)(2)(A).

Section 514(b)(2)(B) of ERISA provides:

Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. §1144(b)(2)(B).

Section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law of 1984 (the "Motor Vehicle Law") provides:

In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits in lieu thereof paid or payable under section 1719 (relating to coordination of benefits).

75 Pa. Cons. Stat. Ann. §1720 (Purdon 1984).

STATEMENT OF THE CASE

FMC, like many other employers, operates a self-funded employee benefit plan, the FMC Salaried Health Care Plan (the "Health Plan").[1] (C1)[2] The Health Plan

[1] Self-funded plans cover a vast number of American workers. More than 9½ million Americans are covered by health funds that are self-funded. "Employee Benefits in Medium and Large Firms, 1988", U.S. Department of Labor, Bureau of Labor Statistics, Bulletin 2336 (August 1988). Moreover, a 1986 study by the Health Care Financing Administration (a division of the U.S. Department of Health and Human Services) revealed that four out of every five companies and unions, with 5,000 or more plan participants, operated self-funded health care plans. P. McDonnell, A. Guttenberg, L. Greenberg, R.H. Arnett III, "Self-Insured Health Plans," *HCFA Review*, Vol. 8 No. 2 (1986). The HCFA study also found that more than 50 percent of all employees with health insurance participate in self-funded plans.

[2] The district court disposed of this case on cross-motions for summary judgment, finding that there were no disputed

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covers medical expenses incurred by FMC employees and their covered dependents. All funds used by the Health Plan to provide medical benefits to the participants come directly from FMC; FMC does not purchase insurance to provide these benefits. (C1)

The fiscal integrity of the Health Plan is maintained through, among other ways, the exercise of subrogation rights. The Health Plan provides:

> The FMC self-insured benefit program is automatically assigned the right of action against third parties in any situation in which benefits are paid to employees or their dependents. If you bring a liability claim against any third party, benefits payable under this Plan must be included in the claim, and when the claim is settled you must reimburse the Plan for the benefits provided.

(C2)

Cynthia Ann Holliday ("Holliday") is the daughter of Gerald Holliday, an FMC employee. Mr. Holliday subscribed to FMC's Health Plan, and his daughter was a covered dependent. (C1) The Health Plan paid a substantial portion of the approximately $178,000 in medical expenses incurred by Ms. Holliday in connection with injuries she suffered in an automobile accident. (C1)

FMC learned that the Hollidays filed a tort action in Pennsylvania state court (the "Pennsylvania Action")

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material facts. The facts referred to in this section were those relied upon by the district court in its opinion.

against the negligent driver[3] and notified the Hollidays that it intended to exercise its subrogation rights with respect to any recovery. (C2) The Hollidays rejected FMC's claim, contending that Section 1720 of the Motor Vehicle Law prohibits such subrogation.[4] (C3) Thereupon, FMC sought a declaratory judgment from the district court.[5]

Both FMC and Ms. Holliday moved for summary judgment. The district court (Bloch, J.) found that there were no disputed material facts, granted Ms. Holliday's

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[3] On May 2, 1989, the state court in the Pennsylvania Action approved a settlement agreement whereby $49,875.50 plus accrued interest was placed in an escrow account in the name of Ms. Holliday.

[4] Section 1720 provides:

> In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits in lieu thereof paid or payable under section 1719 (relating to coordination of benefits).

75 Pa. Cons. Stat. Ann. §1720 (Purdon in 1984). Both the district court and the Court of Appeals held, before reaching the preemption question presented to this Court, that by its terms Section 1720 applies to self-funded plans, such as the Health Plan.

[5] The jurisdiction of the district court was invoked under 28 U.S.C. §1332 because of diversity of citizenship, FMC being a citizen of Delaware, with its principal place of business in Illinois, and Holliday being a citizen of Pennsylvania.

motion and denied FMC's motion. *FMC Corp. v. Holliday*, No. 88-1098 (W.D. Pa. March 14, 1989). (C1)

The Court of Appeals affirmed the district court's decision, holding: (1) that Section 1720 of the Motor Vehicle Law applies to self-funded plans and thus precludes FMC from exercising its contractual subrogation rights, *FMC*, 885 F.2d at 83; and (2) that Section 514 of ERISA does not preempt Section 1720 of the Motor Vehicle Law from application to FMC's self-funded Health Plan since Section 1720 does not conflict with a core type of ERISA matter. *Id*. at 83-90. The Court of Appeals' holding on the preemption question brings FMC to this Court.

REASONS FOR GRANTING THE WRIT

1. A Substantial and Direct Conflict Among the Courts of Appeals Exists and Will Be Resolved By a Decision in This Case.

In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), this Court held that ERISA preempts the application of state insurance laws to uninsured, or self-funded, employee welfare benefit plans. *Id*. at 741, 747. In so doing, this Court gave life to the distinction between insured and self-funded plans which Congress created in the so-called "deemer clause" of ERISA's preemption statute, Section 514(b)(2)(B). However, a conflict over whether ERISA preempts all state insurance laws as applied to self-funded plans now exists among the circuits.

Since *Metropolitan Life*, seven Courts of Appeals have considered whether Congress intended to preempt all state insurance laws as applied to self-funded benefit plans. Five Courts, the Fourth, Fifth, Seventh, Eighth and Ninth, have followed *Metropolitan Life*, holding that Section 514 of ERISA prohibits states from regulating self-funded benefit plans.[6] However, two Courts, including the Court of Appeals in this case, have ignored Congress and the plain language of the statute, have summarily dismissed the relevant holding in *Metropolitan Life* as *dictum*, and have created two different tests to determine the scope of the "deemer clause."[7] This direct conflict

[6] *See Baxter v. Lynn*, 886 F.2d 182, 186, *reh'g denied*, ___ F.2d ___ (8th Cir. 1989) (noting that even if state subrogation law had been saved from preemption as a law that regulated insurance, the "deemer clause" of Section 514 clearly prevents application of the subrogation law to a self-funded benefit plan); *Reilly v. Blue Cross and Blue Shield United of Wisconsin*, 846 F.2d 416, 425-26 (7th Cir.), *cert. denied*, 104 S. Ct. 145 (1988) (holding that, regardless whether plaintiff's state law claims fall within insurance savings clause, Section 514 of ERISA preempts those claims when made against self-funded benefit plan); *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157, 1161-62 (9th Cir. 1986) (holding that Section 514 of ERISA prevents application of Arizona anti-subrogation law to self-funded benefit plan); *Powell v. Chesapeake & Potomac Telephone*, 780 F.2d 419, 423 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) (holding that Section 514 of ERISA prevents application of Virginia insurance trade practice laws to self-funded benefit plan); *Children's Hospital v. Whitcomb*, 778 F.2d 239, 242 (5th Cir. 1985) (holding that Section 514 of ERISA prevents application of a Louisiana mandatory benefits law to a self-funded benefits plan).

[7] *FMC Corp. v. Holliday*, 885 F.2d 79, 89-90, *reh'g denied*, ___ F.2d ___ (3d Cir. 1989) (holding that Pennsylvania

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calls for this Court to exercise its jurisdiction to define clearly the breadth of ERISA's preemption provisions. A decision in this case will eliminate confusion and clarify the multiple and conflicting obligations now imposed on self-funded plans by the current disarray in the circuits.[8]

This Court in *Metropolitan Life* employed a three-part analysis following the structure of Section 514 in considering whether state regulation of self-funded benefit

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anti-subrogation law as applied to self-insured benefit plan was not preempted by Section 514 of ERISA because the Pennsylvania law did not "intentionally or unintentionally address[] a core type of ERISA matter which Congress sought to protect by the preemption provision"); *Northern Group Services v. Auto Owners Insurance Co.*, 833 F.2d 85, 89-93 (6th Cir. 1987), *cert. denied*, 108 S. Ct. 1754 (1988) (holding that Michigan coordination of benefits law as applied to self-funded benefit plan was not preempted by ERISA because in that case there was no ERISA interest in uniformity which outweighed the interest in state regulation of insurance).

There is also a Third Circuit decision in accord with the majority of circuits and *Metropolitan Life*. *See Insurance Board of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408, 410-13 (3d Cir. 1987) (holding that Pennsylvania's mandated benefits law could not be applied to a self-funded benefit plan because it was preempted by ERISA).

[8] The imposition of conflicting obligations is not merely hypothetical. Indeed, FMC's Health Plan itself has been subjected to conflicting decisions on the specific issue of whether the "deemer clause" prevents application of state anti-subrogation laws to its self-funded plan. *Compare FMC v. Holliday*, 885 F.2d 79 (3d Cir. 1989) *with FMC Corp. v. Good Samaritan Hospital of the Santa Clara Valley*, (No. C-88-3092 – FMS) (N.D. Cal. December 5, 1988). (D1)

plans is preempted by ERISA.[9] It is at the critical third step, the analysis of the "deemer" clause, where the conflict among the circuits lies.

First, Section 514(a), ERISA's broad preemption provision, provides that ERISA shall preempt "any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." §514(a), 29 U.S.C. §1144(a). "The phrase 'relate to' was given its broad common-sense meaning, such that a state law 'relate[s] to' a benefit plan 'in the normal sense of the phrase, if it has a connection with or reference to such a plan.' " *Metropolitan Life*, 471 U.S. at 739, quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983).

Second, Section 514(b)(2)(A), the so-called "insurance savings" clause, provides that ERISA does not preempt any state law "which regulates insurance, banking or securities." 29 U.S.C. §1144(b)(2)(A). A state law "regulates insurance" if it meets the common-sense requirement that it is specifically directed toward some aspect of the insurance industry, *see FMC*, 885 F.2d at 86, citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, ___ (1987), or if it falls within the reference in the McCarran-Ferguson Act,

[9] The Court of Appeals below belittled this Court's analysis as "stating the obvious more than providing guidelines for surmounting [the] difficulties" in interpreting ERISA's preemption provisions. *FMC*, 885 F.2d at 84.

15 U.S.C. §1011 *et seq.*, to the "business of insurance." *Metropolitan Life,* 471 U.S. at 742-43.[10]

Section 514(b)(2)(B), ERISA's "deemer clause," limits the reach of the insurance savings clause, providing:

> Neither an employee benefit plan nor any trust established under such a plan, shall be deemed to be an insurance company . . . for the purposes of any law of any state purporting to regulate insurance companies [or] insurance contracts.

29 U.S.C. §1144(b)(2)(B).

Thus, the "deemer clause," as interpreted in *Metropolitan Life* and by the Fourth, Fifth, Seventh, Eighth and Ninth Circuits, along with the Third Circuit in *Muir,* prohibits the application of any state insurance law to a self-funded employee benefit plan.[11] These cases applied this bright-line test: if a state purports to apply its insurance law to a self-funded plan, it is preempted by virtue of the "deemer clause."

[10] The three factors relevant to whether a practice falls within the "business of insurance" are "*first,*-whether the practice has the effect of transferring or spreading a policyholder's risk; *second,* whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third,* whether the practice is limited to entities within the insurance industry." *Metropolitan Life,* 471 U.S. at 743, quoting *Union Labor Life Ins. Co. v. Pireno,* 458 U.S. 119, 129 (1982) (emphasis in original).

[11] *See Baxter,* 886 F.2d at 186; *Reilly,* 846 F.2d at 425-26; *Muir,* 819 F.2d at 410-13; *Pacyga,* 801 F.2d at 1161-62; *Powell,* 780 F.2d at 423; *Whitcomb,* 778 F.2d at 242.

The Court of Appeals below and the Sixth Circuit in *Northern Group Services* turn their backs on this bright line test, essentially rewriting Section 514(b)(2)(B) of ERISA, and creating two different, but equally amorphous, tests for determining when ERISA preempts state insurance laws. These two decisions not only contravene precedent and the clear language of the statute; they also make constant litigation over the scope of the "deemer clause" inevitable.[12]

The test created by the Court of Appeals below to govern the scope of the "deemer clause" is as follows:

> [T]he proper inquiry under the deemer clause is whether the state insurance regulation intentionally or unintentionally addresses a core type of ERISA matter which Congress sought to protect by the preemption provision. The court, reviewing a state insurance law, should inquire whether the law conflicts with any substantive mandate in ERISA.

FMC, 885 F.2d at 89-90. The Court of Appeals acknowledged that the "deemer clause" and *Metropolitan Life* require courts to observe the distinction between insured and self-insured plans, but asserted that under *FMC* "*insured plans would per se* survive the deemer clause, while self-insured plans would merely be considered on a

[12] Indeed, such confusion is clearly evident in a recent Sixth Circuit decision in which the panel purports to follow *Northern Group Services* but holds that *the same Michigan insurance law* which was held not to be preempted by the *Northern Group Services* panel is, in fact, preempted by ERISA – but only because of an "added gloss" given to the interpretation of the Michigan statute. *Liberty Mutual Insurance Group v. Iron Workers Health Fund of Eastern Michigan,* 879 F.2d 1384, 1387-88, *reh'g denied,* ___ F.2d ___ (6th Cir. 1989).

case-by-case basis as to whether the state regulation involved affects a central concern of ERISA." *FMC*, 885 F.2d at 89.

On the other hand, the Sixth Circuit in *Northern Group Services* employed a "presumption" against preemption and a selective analysis of "[c]ertain aspects of the legislative history" to fashion the following test:

> [I]n the absence of a showing of state purpose specifically to regulate the content of welfare benefits provided by ERISA, the effect of the deemer clause should be assessed by a balancing of the interests in federal uniformity against those of state primacy in the regulation of insurance.

Northern Group Services, 833 F.2d at 92-93. Both *FMC* and *Northern Group Services* require a case-by-case preemption inquiry, in stark contrast with the bright-line analysis of *Metropolitan Life* and its progeny. Moreover, the Sixth Circuit's test differs significantly from the test created by the Third Circuit in that the former employs a balancing test, weighing the federal interest in uniformity with state interest in regulating insurance, while the Third Circuit test will have district courts engaging, without direction, in defining "core" ERISA concerns. Only state laws conflicting with such concerns will be preempted. Not only do the tests set forth by the Sixth Circuit and the Third Circuit differ from each other, but they also differ from the majority of circuits and *Metropolitan Life*.[13]

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[13] In contrast to this Court in *Metropolitan Life* and the majority of circuits, the courts in *FMC* and *Northern Group*

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Thus, a substantial conflict exists among the Courts of Appeals on the question whether Section 514 of ERISA absolutely preempts state insurance law as applied to self-funded benefit plans. Six of the eight Courts of Appeals considering the issue have protected self-funded benefit plans from potentially conflicting and inconsistent state regulations.[14] The other two panels have rewritten ERISA's preemption section (*see* note 13, *supra*), have set forth different tests by which district courts are to decide the preemption issue and have opened the door for state encroachment on this area of exclusive federal regulation.[15] The

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Services presume that self-insured plans are, in fact, "in the business of insurance" and are thus subject to state insurance regulation. This premise flies in the face of the plain language of ERISA's deemer clause which flatly states that an employee benefit plan is not to be deemed to be engaged in the business of insurance for purposes of any state laws purporting to regulate insurance. *See Kilmer v. Central Counties Bank*, 623 F.Supp. 994, 1001 (attempt to treat self-insured plan as if it were an insurance company flies in the face of the deemer clause). The Court of Appeals makes this unsupported presumption, it candidly states, so that the three ERISA preemption provisions will "make sense." (A23)

[14] *Baxter v. Lynn*, 886 F.2d 182, *reh'g denied*, ___ F.2d ___ (8th Cir. 1989); *Reilly v. Blue Cross and Blue Shield United of Wisconsin*, 846 F.2d 416 (7th Cir.), *cert. denied*, 104 S.Ct. 145 (1988); *Insurance Board of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3d Cir. 1987); *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986); *Powell v. Chesapeake & Potomac Telephone*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986); *Children's Hospital v. Whitcomb*, 778 F.2d 239 (5th Cir. 1985).

[15] *FMC Corp. v. Holliday*, 885 F.2d 79, *reh'g denied*, ___ F.2d ___ (3d Cir. 1989); *Northern Group Services v. Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 108 S.Ct. 1754 (1988).

existence of three separate tests by which district courts and plan administrators are to determine whether a state insurance law is preempted by ERISA squarely presents this Court with the opportunity to resolve a substantial and ripe conflict among the circuits and to prevent much unnecessary litigation.

2. The Third Circuit's Decision Below Is Erroneous and Conflicts With This Court's Decision in *Metropolitan Life*

The Court of Appeals below flatly rejected this Court's decision in *Metropolitan Life* and criticized the opinion because "the Court cited neither statutory text nor legislative history" in arriving at its distinction between insured and self-funded plans, but instead relied "on vague language in Congress' *post hoc* study." *FMC*, 885 F.2d at 89. The court below ultimately concluded that reliance upon the distinction between insured and self-funded plans set forth in *Metropolitan Life* was "not proper in the face of [the] direct consideration of congressional intent" undertaken in both *FMC* and *Northern Group Services*. *FMC*, 885 F.2d at 89. The Court of Appeals' cavalier treatment of *Metropolitan Life* reveals that it either ignored or misunderstood that decision.

In *Metropolitan Life*, this Court decided that ERISA did not preempt a Massachusetts statute which, as applied to plans that purchased insurance, required that certain minimum mental-health-care benefits be provided to Massachusetts residents covered by an *insured* employee health-care plan. *Metropolitan Life*, 471 U.S. at

738-47.[16] However, to decide whether the mandated-benefits statute at issue was among those insurance laws which Congress intended to protect from preemption with the "insurance savings clause," this Court first analyzed the structure of Section 514 of ERISA, in particular the relationship between the "insurance savings clause" and the "deemer clause." *Id.* at 740-41.

Specifically, this Court defined the reach of the insurance savings clause by determining the scope and purpose of the "deemer clause." The purpose of the "deemer clause," as decided in *Metropolitan Life*, is this:

> [T]he deemer clause makes explicit Congress' intention to include laws that regulate [the terms of] insurance contracts within the scope of the insurance laws preserved by the savings clause. Unless Congress intended to include laws regulating insurance contracts within the scope of the insurance savings clause, *it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans.*

Id. at 741 (emphasis added).[17] Accordingly, state laws regulating the terms of insurance contracts, such as the anti-subrogation statute in the instant case, are explicitly

[16] Massachusetts conceded that the "mandated-benefits" statute at issue could not be applied to self-funded benefit plans in light of the "deemer clause." *See Id.* at 735 n.14.

[17] Ironically, the Court of Appeals below acknowleged and cited with approval this language from *Metropolitan Life*, but proceeded to ignore it in reaching its novel result. (A17)

exempted "from the saving clause [and thus preempted by ERISA] when they are applied directly to benefit plans." *Id.*[18]

This Court's analysis in *Metropolitan Life* established a bright-line test: If a benefit plan is self-funded, state insurance laws are preempted. As the Court stated:

> Our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing, we merely give life to a distinction Congress is aware of and one it has chosen not to alter.

Metropolitan Life, 471 U.S. at 747 (footnote omitted). The Court of Appeals' dismissal of this language as *dictum* is plainly unwarranted.

This Court not only concluded that ERISA preempts state insurance laws applied directly to benefit plans, *see id.* at 741, 747, but also expressly considered in *Metropolitan Life* some of the same legislative history upon which the Third and Sixth Circuits based their contrary decisions in *FMC* and *Northern Group Services*. *Compare id.* at 745-46 nn.23-24 *with FMC*, 885 F.2d at 87, *and Northern Group Services*, 833 F.2d at 93 n.3. Nowhere, however, did this Court mention the concern so prominent in the *FMC* and *Northern Group Services* opinions, *i.e.*, that by use of the "deemer clause" Congress sought to prevent *only* "back-door" or "pretextual" attempts by the states to

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[18] Section 1720 of the Pennsylvania Motor Vehicle Law regulates the terms of insurance contracts as certainly as the mandated benefits provision in *Metropolitan Life* did – only Section 1720 limits the types of permissible provisions instead of requiring certain additional provisions.

regulate ERISA plans. *See FMC*, 885 F.2d at 86-88; *Northern Group Services*, 833 F.2d at 92-93. Accordingly, the only logical conclusion is that the outcome-oriented analysis of the legislative history undertaken by the Third and Sixth Circuits is incorrect. Therefore, this Court should exercise its jurisdiction to prevent the perpetuation of the Third Circuit's misunderstanding of *Metropolitan Life*.

3. This Case Presents an Important and Recurring Question of Law.

This Court should exercise its jurisdiction to correct the Court of Appeals' erroneous decision in *FMC* because the pernicious effects of *FMC* and *Northern Group Services* will significantly and adversely affect the administration of thousands of self-funded benefit plans.

First, the Court of Appeals below adopted its test for restricting the scope of the "deemer clause" despite acknowledging that Congress had considered and flatly rejected precisely such a formulation with respect to defining the scope of Section 514(a), ERISA's broad preemption clause, because "it raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation." *FMC*, 885 F.2d at 88 (quoting Senator Javits).[19] Thus, *FMC* and *Northern Group*

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[19] Senator Javits, one of the architects of ERISA, explained that Congressmen viewed earlier versions of House and Senate bills defining the perimeters of preemption in relation to the areas regulated by ERISA as problematic since "[s]uch a formulation raised the possibility of endless litigation over the

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Services invite precisely the type of endless litigation that ERISA's drafters sought to preclude.

Second, as the Court of Appeals below conceded, central to Congress' efforts in drafting the broad preemption provision was the goal of achieving federally uniform regulation of employee benefit plans. *FMC*, 885 F.2d at 88.[20] Congress believed that by preempting the field, but for certain specified exceptions like the savings clause, it had achieved its goals of encouraging employers to establish benefit plans and of protecting benefit plan participants and beneficiaries from encroachments on their plans by eliminating the threat of conflicting and inconsistent state and local regulation.[21] The tests

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validity of State action that might impinge on Federal regulation, as well as opening the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme." 120 Cong. Rec. 29942 (1974). To prevent this from occurring, Congress deliberately made the preemption provisions expansive in scope, as this Court observed in *Pilot Life*.

[20] *See also* 120 Cong. Rec. 29942 (1974) (statement of Senator Jacob Javits) ("[T]he emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required – but for certain exceptions – the displacement of State action in the field of private employee benefit programs") and 120 Cong. Rec. 29933 (1974) (statement of Sen. Harrison Williams, Jr.) (preemption of the field intended to apply in its broadest sense with only the exceptions specified in the act).

[21] *See* Staff of Senate Comm. on Labor and Public Welfare, 94th Cong. 2d Sess., Legislative History of ERISA 4670 (Comm.

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adopted by the Third and Sixth Circuits undercut these Congressional goals by requiring courts to engage in a case-by-case, outcome-oriented analysis that will prove a useful vehicle for the application of conflicting and inconsistent state laws to employee benefit plans. The likelihood of such outcome-oriented analysis is vividly illustrated by the Sixth Circuit's decision in *Liberty Mutual*, where the Sixth Circuit panel purportedly applied the test set forth in *Northern Group Services* but reached an opposite conclusion regarding the preemption of the same Michigan insurance statute at issue in *Northern Group Services*. *See Liberty Mutual*, 879 F.2d at 1387-88.

Third, both Courts of Appeals ignored the fact that Congress established benefit plan regulation as exclusively a federal concern to minimize the need for interstate employers such as FMC to administer their plans differently in each state in which they have employees. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983). Congress recognized the administrative realities of employee benefit plans and sought to promote an employer's capacity to provide benefits to employees scattered throughout many states in the most efficient manner, *i.e.*, through a single employee benefit plan.

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Print 1976) (statement of U.S. Rep. John Dent) ("I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent state and local regulation.")

Shaw, 463 U.S. at 105 n.25. As this Court stated in *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 11 (1987):

> It is thus clear that ERISA's preemption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Preemption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.

At the ultimate expense of plan participants and beneficiaries, the Court of Appeals' holding below will indubitably subject the Health Plan to conflicting or inconsistent state laws.[22] Indeed, FMC's Health Plan itself has already been subjected to conflicting decisions regarding the application of state anti-subrogation laws. A district court in California held, in direct conflict with this case, that a California anti-subrogation statute is preempted as applied to FMC's Health Plan. *See Good*

[22] The Court of Appeals' opinion below paves the way for a direct assault on the fiscal integrity of self-funded plans, such as that operated by FMC. The Health Plan regenerates itself through subrogation, and the inability to exercise this contract right, because of the Motor Vehicle Law's anti-subrogation provision, may force the Health Plan to reduce benefits to participants and beneficiaries. Congress feared this very scenario and drafted ERISA's preemption provisions with a broad brush to prevent its occurrence.

Samaritan, supra. (D1) It is precisely this burden, to both plans and participants, that ERISA's preemption provisions are intended to avoid. *See, Fort Halifax*, 482 U.S. at 10.

Finally, a decision in this case will affect the operation of thousands of self-funded plans and the rights of millions of plan participants. Outcome-oriented tests and analyses, such as those created and utilized in the Third and Sixth Circuits, not only undermine the Congressional goal of a federal, uniform system of health benefit administration, but also will ultimately lead to the restriction of plan benefits – or to the crippling of plans themselves – to the potential detriment of millions of American workers. Congress clearly did not intend such a result.

CONCLUSION

For the foregoing reasons, a writ of certiorari should issue to the United States Court of Appeals for the Third Circuit.

December 29, 1989

Respectfully submitted,

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APPENDIX A

FMC CORPORATION, Appellant,

v.

Cynthia Ann HOLLIDAY, Appellee.

No. 89-3226.

United States Court of Appeals,
Third Circuit.

Argued July 25, 1989.

Decided Sept. 11, 1989.

Employer which operated health plan and which employed father of injured motor vehicle passenger appealed from an order of the United States District Court for the Western District of Pennsylvania, Alan N. Bloch, J., granting summary judgment in favor of passenger in employer's action seeking declaratory judgment that it was entitled to subrogation against passenger's recovery for personal injuries. The Court of Appeals, Gibbons, Chief Judge, held that: (1) employer's subrogation claim was barred by Pennsylvania Motor Vehicle Financial Responsibility Law, and (2) anti-subrogation provision of statute was not preempted by ERISA.

Affirmed.

Charles Kelly [argued], H. Woodruff Turner, Stephen M. Rosenblatt, Kirkpatrick and Lockhart, Pittsburgh, Pa., for appellant.

Thomas G. Johnson [argued], Malcolm & Johnson, Indiana, Pa., for appellee.

Before GIBBONS, Chief Judge, HUTCHINSON, Circuit Judge and WOLIN, District Judge*.

OPINION OF THE COURT

GIBBONS, Chief Judge:

FMC Corporation appeals from a summary judgment in favor of the defendant Cynthia Ann Holliday, in FMC's action seeking a declaratory judgment that it is entitled to subrogation against Ms. Holliday's recovery for personal injuries received in an automobile accident. FMC is an employer operating a health plan and employs Ms. Holliday's father. She was permanently injured, and FMC has paid and will in the future pay her medical expenses pursuant to that plan. The district court held that under Pennsylvania law FMC had no subrogation rights, and that Pennsylvania law was not preempted by section 514 of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1144. FMC contends the district court erred in both respects. We will affirm.

I.

On January 16, 1987, Ms. Holliday, then age 15, was seriously and permanently injured while riding as an automobile passenger in Indiana County, Pennsylvania. Her medical expenses to date exceed $178,000 and the cost of future care is unknown. At the time of the accident her father owned an automobile policy issued by State Farm Mutual Automobile Insurance Company, which

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*Hon. Alfred M. Wolin, United States District Judge for the District of New Jersey, sitting by designation.

paid the first $10,000 of his daughter's medical bills. Mr. Holliday also commenced a negligence action on behalf of his daughter in the Court of Common Pleas of Indiana County against Robert Lyons, the driver of the car in which she was a passenger at the time of the accident. That case proceeded to an eventual settlement on September 3, 1987, under which Lyons interpleaded his $100,000 automobile liability policy in favor of Ms. Holliday and three other claimants injured in the accident. Ms. Holliday's recovery was limited to $49,875.50 plus accrued interest.

At the time of the accident Mr. Holliday was also a covered employee under FMC's Salaried Health Plan, which provided benefits for dependents. That plan contains coordination of benefits clauses as follow:

> If you or a covered member of your family are eligible to receive benefits under another group medical plan, Health Maintenance Organization (HMO), government plan, or by "no-fault" automobile insurance which provides medical coverage, you may be eligible for benefits from those Plans and your FMC plan. In the case of coverage by "no-fault" automobile insurance, FMC will pay covered expenses not paid for by no-fault insurance.
>
> * * *
>
> *No-Fault*
>
> In some states with no-fault motor vehicle coverage, the carrier is the primary insurer in these jurisdictions. All medical expenses related to an accident must be submitted to the carrier and not the FMC Health Care Plan. Eligible expenses not paid for by no-fault insurance *will* be paid by the FMC Plan.

Relying on these clauses FMC commenced paying Ms. Holliday's medical expenses only when the $10,000 no-fault coverage under her father's State Farm automobile policy was exhausted. That $10,000 is not in dispute.

The FMC Salaried Health Plan also contains a subrogation clause as follows:

> The FMC self insured benefit program is automatically assigned the right of action against third parties in any situation in which benefits are paid to employees or their dependents. If you bring a liability claim against any third party, benefits payable under this Plan must be included in the claim, and when the claim is settled you must reimburse the Plan for the benefits provided. You are obligated to avoid doing anything which would prejudice the Plan's rights of reimbursement, and you are required to sign and deliver documents to evidence or secure those rights. *Unless you sign the Company's "third party reimbursement form," the Claims Administrator will not process any claim where there is possible liability on behalf of a third party.*

(emphasis supplied). In order to obtain reimbursement of medical expenses in excess of $10,000, Mr. Holliday signed a third-party reimbursement form, and the Salaried Health Plan thereafter paid his daughter's medical expenses.

When FMC learned of the negligence action in Indiana county it notified the Hollidays that it intended to exercise its subrogation rights with respect to that liability claim. The Hollidays responded that 75

Pa.Cons.Stat.Ann. § 1720 of the Pennsylvania Motor Vehicle Law prohibits such subrogation. This declaratory judgment action followed.

II.

FMC contends that the court erred in holding that the exercise of its subrogation rights is barred by the relevant Pennsylvania law. The governing statute is the Pennsylvania Motor Vehicle Financial Responsibility Law, Act of Feb. 12, 1984, No. 11, § 3, 1984 Pa.Laws 28, as amended by Act of Feb. 12, 1984, No. 12, § 3, 1984 Pa. Laws 53, 75 Pa. Cons.Stat.Ann. §§ 1701-1798 (Purdon 1988), which is a comprehensive effort to establish a uniform system for the prompt payment of economic losses suffered by victims of vehicular collisions, including coverage for medical expenses arising out of the maintenance or use of a motor vehicle. *See Pennsylvania Legislative Journal*, 167th Sess., Oct. 4, 1983, at 1147 (comments of Sen. Holl); *id.*, 167th Sess., Dec. 14, 1983, at 2241 (comments of Rep. Manderino). Two provisions of the Motor Vehicle Law bear directly on this case: section 1720, which bars the assertion of subrogation rights; and section 1719, which helps define the scope of section 1720.

Section 1720 precludes subrogation with reference to a broad range of insurance arrangements:

> In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating

to availability of adequate limits) or benefits in lieu thereof paid *or payable under section 1719 (relation to coordination of benefits).*

75 Pa.Cons.Stat.Ann. § 1720 (emphasis added). The coordination of benefits provision reads:

(a) *General rule.* – Except for workers' compensation, a policy of insurance issued or delivered pursuant to this sub-chapter shall be primary. Any program, group contract or other arrangement for payment of benefits such as described in section 1711 (relating to required benefits) 1712(1) and (2) (relating to availability of benefits) or 1715 (relating to availability of adequate limits) shall be construed to contain a provision that all benefits provided therein shall be in excess of and not in duplication of any valid and collectible first party benefits provided in section 1711, 1712 or 1715 or workers' compensation.

(b) *Definition.* – As used in this section the term "program, group contract or other arrangement" includes, *but is not limited to,* benefits payable by a hospital plan corporation or a professional health service corporation subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

75 Pa.Cons.Stat.Ann. § 1719 (emphasis added).

The FMC Salaried Health Plan clearly falls within the plain meaning of section 1719. First, the Motor Vehicle Law elsewhere defines the term "benefits" to include "medical benefits". 75 Pa.Cons.Stat.Ann. § 1702. Second, section 1719(b) expressly employs non-exclusive language in defining the types of programs the statute covers. Finally, FMC effectively availed itself of section

1719's coordination of benefits formula in the Salaried Health Plan's parallel clauses quoted above. FMC's counterarguments are without merit. In a reading anything but plain, the corporation contends that the use in section 1719 of the phrase "group contract," an insurance term of art, indicates a clear intent to regulate only entities whose primary purpose is providing insurance or health care services. In itself a questionable interpretation of the term "group contract," FMC's argument ignores section 1719's use of two other patently non-exclusive terms, namely, "program" and "other arrangement." ERISA uses the terms "plan, fund or program" to define ERISA plans, 29 U.S.C. § 1002(1); the phrase "other arrangements" could scarcely be more broad on its face.

Pointing to the fact that subrogation is a long-established principle in Pennsylvania law, FMC urges that the Financial Responsibility law should be presumed not to have made any change in that principle unless the legislature was more specific. That position, however, is inconsistent with Pennsylvania's statute on statutory interpretation providing, at least since 1937, that statutes in derogation of the common law in general "be liberally construed to effect their objects and promote justice." 1 Pa.Cons.Stat.Ann. § 1928(c) (Purdon 1989).[1] FMC's

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[1] Pennsylvania's statute on statutory interpretation does provide for strict construction for certain categories, but the Motor Vehicle Law falls into none of them. The full provision reads:

(Continued on following page)

reliance on *Commonwealth v. Miller*, 469 Pa. 24, 364 A.2d 886, 887 (1987), moreover, is unavailing since that case

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(Continued from previous page)

§ 1928. Rule of strict and liberal construction

(a) The rule that statutes in derogation of the common law are to be strictly construed, shall have no application to the statutes of this commonwealth enacted finally after September 1, 1937.

(b) All provisions of a statute of the classes hereafter enumerated shall be strictly construed:

(1) Penal provisions.

(2) Retroactive provisions.

(3) Provisions imposing taxes.

(4) Provisions conferring the power of eminent domain.

(5) Provisions exempting persons and property from taxation.

(6) Provisions exempting property from the power of eminent domain.

(7) Provisions decreasing the jurisdiction of a court of record.

(8) Provisions enacted finally prior to September 1, 1937 which are in derogation of the common law.

(c) All other provisions of a statute shall be liberally construed to effect their objects and to promote justice.

1 Pa.Cons.Stat.Ann. § 1928 (Purdon 1988).

deals with criminal statutes, which as a class are among the exceptions to be strictly construed. It is well settled that insurance statutes, in contrast, fall into the primary class and are meant for liberal interpretation. *Antanovich v. Allstate Ins. Co.*, 320 Pa.Super. 322, 327, 467 A.2d 345, 348 (1983), *aff'd*, 507 Pa. 68, 488 A.2d 571 (1985); *Miller v. United States Fidelity & Guar. Co.*, 304 Pa.Super. 43, 54, 450 A.2d 91, 97 (1982), *aff'd*, 503 Pa. 127, 468 A.2d 1097 (1983).

FMC's alternative argument from statutory interpretation, that the Financial Responsibility Law employs language making it more restrictive than its predecessor statute, fares no better. The earlier act, the Pennsylvania No-fault Motor Vehicle Insurance Act of 1974, Pa.Stat.Ann. tit. 40, §§ 1009.101-1009.701 (Purdon 1989) (repealed), contained sweeping antisubrogation language. Under section 1009.111(a)(4) of the No-fault Act, "[i]n no event shall any entity providing benefits other than no-fault benefits to an individual as described in section 203 of this act, [Section 1009.203 of this title] have any right of subrogation with respect to said benefits." FMC attempts to make use of the alteration of this wording by first noting the common sense rule-of-thumb that different words in a subsequent statute on the same or a related topic indicate that the legislature must have intended a different meaning. *Klein v. Republic Steel Corp.*, 435 F.2d 762, 765-66 (3d Cir.1970). It then argues that the manifestly narrower language of the antisubrogation provision in the current Motor Vehicle law betokens an intent to excuse self-insured health care benefit programs such as FMC's. These arguments must be rejected. The current statute's use of the terms "program, group contract or other arrangement" appears hardly less broad than the

"any entity" language of the No-fault Law. Moreover, nothing in either the statute or the legislative history indicates any substantive intent to exclude programs like the FMC plan from the ambit of the bar to subrogation. The scant legislative history that does exist indicates to the contrary, a desire to apply the prohibition broadly for the sake of uniformity and consistency. *See Pennsylvania Legislative Journal*, 167th Sess., Oct. 4, 1983, at 1147 (comments of Sen. Holl); *id.*, 167th Sess., Dec. 14, 1983, at 2241 (comments of Rep. Manderino).

We hold, therefore, that the district court did not err when it ruled that FMC's subrogation claim is barred by the Pennsylvania Financial Responsibility Law. That holding requires that we address FMC's preemption contention.

III.

FMC, relying on *United Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga*, 801 F.2d 1157 (9th Cir.1986), contends that section 514 of ERISA categorically exempts from state regulation all self-funded employee benefit programs, and that such preemption reaches state law modifications of the common law of subrogation. Ms. Holliday, relying on *Northern Group Services, Inc. v. Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir.1987), contends that Congress did not intend such categorical preemption. Rather, she urges, Congress intended to shield employee benefit programs only from state law that encroaches on ERISA concerns in the guise of insurance regulation. The question of preemption by ERISA of statutory changes in subrogation

law, when those changes are effected by state no-fault insurance statutes, has not been presented to this court.[2]

ERISA's section 514, 29 U.S.C. § 1144, is hardly a model of legislative draftsmanship. The section deals with preemption, but congressional intention must be gleaned from the interrelationship among a "preemption" clause, a "savings" clause, and a "deemer" clause.

The "preemption" clause broadly provides, in relevant part:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . .

29 U.S.C. § 1144(a). The "savings" clause, however, appears to restore virtually all the state regulation that the "preemption" clause invalidates, at least so far as insurance laws are concerned. This provision states:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any persons from any law of any State which regulates insurance, banking, or securities.

29 U.S.C. § 1144(b)(2)(A). Finally, the "deemer" clause in subparagraph (B) apparently brings the reader full circle

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[2] FMC contends that *Insurance Board of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3d Cir. 1987), requires a decision in its favor. The issue before us was not addressed in that case.

by exempting employee benefit plans from state insurance regulation:

> Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(b)(2)(B).

The resulting interpretive difficulties were summarized by the Court of Appeals for the Sixth Circuit, which observed:

> The difficult problem in interpreting the preemption portion of ERISA § 514, 29 U.S.C. § 1144 is defining the scope of each of the three critical clauses so that each has a meaning and so that benefit obligations are governed by a rational system of state law and federal common law. Congress indicated its intention only in a very general way and left to the federal courts the problem of developing on a case-by-case basis principles of preemption of state law.

Northern Group Services, 833 F.2d at 89. Stating the obvious more than providing guidelines for surmounting these difficulties, the Supreme Court has set forth a three-part preemption test that mirrors each of the three provisions. Under this test a court must inquire whether a state law (1) relates to an employee benefit plan; (2) regulates insurance, and (3) survives the "deemer" clause. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739-747, 105 S.Ct. 2380, 2388-2393, 85 L.Ed.2d 728 (1985).

A. *The "Preemption Clause"*

Neither party, nor any court that has dealt with the matter, disputes that the "relates to" language of the preemption clause should be read broadly in general, and broadly enough in particular to cover state no-fault automobile insurance plans. *See Northern Group Services*, 833 F.2d at 87-89. Only the Pennsylvania Trial Lawyers Association, as amicus curiae, suggests otherwise.

The command of the preemption clause that ERISA must preempt "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" suggests a wide application on its face. The Supreme Court sanctioned the plain meaning approach in *Shaw v. Delta Air Lines*, 463 U.S. 85, 96-98, 103 S.Ct. 2890, 2899-2901, 77 L.Ed.2d 490 (1983). Holding that a state law directing health insurers to provide mental health care benefits "clearly" related to ERISA, the Court opined that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw*, 463 U.S. at 96-97, 103 S.Ct. at 2900; *Metropolitan Life*, 471 U.S. at 739, 105 S.Ct. at 2388. Moreover, if the preemption clause had been intended to be read narrowly, the remaining two clauses would have been unnecessary. *Northern Group Services*, 833 F.2d at 89.

Despite their split in outcome, the two Courts of Appeals that have considered antisubrogation laws concur in following *Shaw*. The Sixth Circuit held that Michigan's No-Fault Automobile Insurance Act, and

specifically the statute's coordination of benefits provisions, "directly . . . allocate[d] obligations to make insurance payments contrary to the express coordination-of-benefits language of the [ERISA] plan." *Northern Group Services*, 833 F.2d at 89. In consequence, "[h]olding that this state law does not 'relate to' the plan would run contrary to the plain meaning of the text and to the relevant case law and legislative history." *Id.* Similarly, in *Pacyga* the Court of Appeals for the Ninth Circuit had no difficulty in determining that Arizona's common law rule against subrogation also "relate[d] to" ERISA plans, this despite the Court's ultimate use of the deemer clause to find preemption nonetheless.[3] 801 F.2d at 1160. No other holdings so squarely address the preemption clause aspect of this case.

The Pennsylvania Trial Lawyers nonetheless argue for a more limited application of the preemption clause, relying on cases less apposite than *Shaw*. In the first, the Supreme Court held that Georgia's general garnishment statute did not "relate to" ERISA benefit plans. *Mackey v. Lanier Collections Agency & Ser.*, ___ U.S. ___, 108 S.Ct. 2182, 100 L.Ed.2d 836 (1988). Far from overruling *Shaw* and *Metropolitan Life*, *Mackey* instead finessed a narrow

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[3] The *Pacyga* Court also noted that the Arizona subrogation rule "purported to regulate" ERISA plans as well, a further requirement for finding that a state law "relates to" ERISA. 801 F.2d at 1160. This additional requirement is evidently peculiar to the Ninth Circuit, *Martori Bros. Distributors v. James-Massengale*, 781 F.2d 1349, 1359 (9th Cir.1986), though the Second Circuit uses a version of the "purports to regulate" test to define the regulating "State" under 29 U.S.C. § 1144(c)(2), *see Rebaldo v. Cuomo*, 749 F.2d 133, 137-38 & n. 1 (2d Cir.1984).

exception. The majority, in the face of a four-justice dissent, reasoned that since creditors of ERISA plans are commonly allowed to bring state civil law actions and employ state methods of enforcing judgments, the creditors of plan participants should be able to do the same. *Mackey*, 108 S.Ct. at 2186-89. However questionable its logic, the *Mackey* court's exception to the Court's usual reading of the preemption clause rested exclusively on state laws dealing with the enforcement of civil judgments. The other cases offered are even less on point. Just prior to *Mackey*, the Supreme Court held that a Maine statute mandating a one-time severance payment in the event of a plant closing also did not, in ERISA's words, "relate to any employee benefit plan." *Fort Halifax Packing Co. v. Coyne*, 482 U.S.1, 107 S.Ct. 2211, 96 L.Ed.2d 1 (1987). The *Coyne* Court, however, took pains to distinguish statutes that would affect an ERISA plan on an ongoing basis from those affecting a one-time payment. 107 S.Ct. at 2220; *see Northern Group Services*, 833 F.2d at 88-89. No more compelling is the Trial Lawyers' reliance on *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir.1984). There the Court of Appeals for the Second Circuit held that ERISA did not preempt a state plan regulating hospital insurance rates that only incidentally touched pension plans. This outcome simply accords with *Shaw's* common sense dictum that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." 463 U.S. at 100 n. 21, 103 S.Ct. at 2901 n.21.

Thus we reject the amicus position that the preemption clause should be read narrowly. It is broad enough to cover state antisubrogation laws.

B. *The "Savings Clause"*

Both parties and the amicus agree that the type of antisubrogation provision found in the Pennsylvania Financial Responsibility Law "regulates insurance" within the meaning of the savings clause. This position accords with the two Circuits that have considered the matter. *Northern Group Services*, 833 F.2d at 89-90; *Pacyga*, 801 F.2d at 1160-61. It also accords with the clause's plain meaning and statutory structure, and with formal standards for interpreting general insurance provisions, as developed by the Supreme Court.[4] We agree that Pennsylvania's Financial Responsibility Law plainly "regulates insurance" within the meaning of the savings clause. The statute's coordination of benefits and antisubrogation provisions directly control the terms of insurance contracts. Application of the clause therefore clearly comports with the common sense view of statutory text extended to the savings provision in *Metropolitan Life*, 471

[4] Three years after ERISA's enactment a congressional oversight report noted:

> In general these exemptions [to preemption] are designed to save state law as it is applied to entities which are not employee benefit plans . . . , to the extent that such regulation does not relate to employee benefit plans.

Subcomm. on Labor Standards, House Comm. on Educ. & Labor, ERISA Oversight Report of The Pension Task Force 8 (1977). As the Court of Appeals for the Sixth Circuit opined, "[t]hese subsequent legislators (or their staff) did not seem to recognize or consider the fact that the 'savings' clause would not be necessary at all if it only saves state laws that do not 'relate to' ERISA plans." *Northern Group Services*, 833 F.2d at 89.

U.S. at 740-43, 105 S.Ct. at 2389-2391. The Financial Responsibility Law also meets the further common sense requirement that a state law not merely affect some aspect of the insurance industry, but be specifically directed toward it. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 1554, 95 L.Ed.2d 39 (1987).

The placement within section 514 of the savings clause bolsters this common sense interpretation. The savings clause is followed directly by the deemer clause which states that an employee benefit plan shall not be deemed an insurance company "for purposes of any law of any State purporting to regulate . . . insurance contracts." 29 U.S.C. § 1144(b)(2)(B). "By exempting from the saving clause laws regulating insurance contracts that apply directly to benefit plans, the deemer clause makes explicit Congress' intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause." *Metropolitan Life*, 471 U.S. at 741, 105 S.Ct. at 2389-2390. Insofar as the Financial Responsibility Law expressly regulates insurance contracts, it necessarily falls within the ambit of the savings provision.

Finally, the Supreme Court's standard for determining when a practice constitutes "the business of insurance," developed with reference to the McCarran-Ferguson Act of 1945, 15 U.S.C. §§ 1011-1015, removes any doubt that the Financial Responsibility Law "regulates insurance." Three factors are relevant to the determination:

> *first*,whether the practice has the effect of transferring or spreading the policyholder's risk; *second*, whether the practice is an integral part of

> the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

Metropolitan Life, 471 U.S. at 743, 105 S.Ct. at 2391 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129, 102 S.Ct. 3002, 3009, 73 L.Ed.2d 647 (1982)). Every court that has applied these criteria to coordination of benefits requirements has found the first two criteria easily satisfied. *See Northern Group Services*, 833 F.2d at 90; *Pacyga*, 801 F.2d at 1161. While the Financial Responsibility Law does go beyond the third criterion insofar as it reaches any "program, group, or other arrangement" including health and hospital plans, its principal and substantial effect is nonetheless on the insurance industry. *See Northern Group Services*, 833 F.2d at 90; *Pacyga*, 801 F.2d at 1161.

C. *The "Deemer Clause"*

The deemer clause, which states that no "employee benefit plan . . . shall be deemed to be an insurance company . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts," creates an exception to the savings provision, which itself created an exception to the general preemption clause. 29 U.S.C. § 1144(b)(2)(B). Preemption in this case, therefore, turns on whether FMC's Salaried Health Plan falls within the deemer clause exception insulating employee plans from state regulation. Neither the statutory text, legislative history, nor case law provides a clear answer; this is one reason that the two courts of appeals which addressed it parted company on this precise point. Of the two solutions, *Northern Group Services* comes closer

to the correct interpretation, namely, that the deemer clause is meant mainly to reach back-door attempts by states to regulate core ERISA concerns in the guise of insurance regulation. *See* 833 F.2d at 91-94.

Support for this answer comes from the statutory text. The deemer clause protects ERISA plans from being deemed insurers, or otherwise in the business of insurance, by any state law "purporting" to regulate insurance. Remarks from two of the sponsoring senators support the view that the use of "purporting" betokens a congressional concern only for regulation that was merely a pretext for impinging upon ERISA plans. Senator Javits stated that broad Federal preemption meant to bar "[s]tate laws hastily *contrived* to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme." 120 Cong.Rec. 29,942, *reprinted in* 3 Legislative History of the Employee Retirement Income Security Act of 1974, at 4770-71 (emphasis added). Senator Williams also displayed concern for pretextual state infringements, albeit in the context of professional regulation having the force of state law rather than state insurance laws themselves:

> Consistent with th[e] principle [of broad preemption regarding any action that has the force or effect of law] State professional organizations acting under the *guise* of State-enforced professional regulation, should not be able to prevent unions and employers from maintaining the types of employee benefit programs which Congress has authorized.

120 Cong.Rec. 23,933, *reprinted in* 3 Legislative History of the Employee Retirement Income Security Act of 1974, at

4746 (emphasis added). *See Northern Group Services*, 833 F.2d at 93 n. 3.

The legislative history more generally also offers support for a "pretextual" construction. Initially, both the House and Senate versions of the bill preempted only those state laws concerning ERISA's "fiduciary, reporting and disclosure responsibilities" or relating to "the subject matter" it was to regulate. Both versions also contained a savings clause for state insurance regulation, but neither contained any deemer provision. The first version of the deemer clause did not arise until the Houses replaced the language of the original H.R. 2 with that of H.R. 12,906 just prior to passage of the preconference bill. This new version, including a narrower progenitor of the preemption clause and an earlier model of the savings provision, read:

> EFFECT ON OTHER LAWS
>
> SEC. 514. (a) It is hereby declared to be the express intent of Congress that . . . the provisions of part 1 of this subtitle shall supersede any and all laws of the States and of political subdivisions thereof insofar as they may now or hereafter relate to the reporting and disclosure responsibilities, and fiduciary responsibilities, of persons acting on behalf of any employee benefit plan to which part 1 applies.
>
> (b) Nothing in part 1 of this subtitle shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities or to prohibit a State from requiring that there be filed with a State agency copies of

> reports required by this title to be filed with the Secretary. *No employee benefit plan subject to the provisions of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.*
>
> (c) It is hereby declared to be the express intent of Congress that the provisions of parts 2, 3, and 4 of this subtitle shall supersede any and all laws of the States and of political subdivisions thereof insofar as they may now or hereafter relate to the nonforfeitability of participant's benefits in employee benefit plans . . . , the funding requirements for such plans, the adequacy of financing of such plans, portability requirements for such plans, or the insurance of pension benefits under such plans.

2 Legislative History of the Employee Retirement Income Security Act of 1974, at 2920-22 (emphasis added). The Senate version included no comparable deemer language.

Before the conference, the committee declared itself to be divided on whether the House version, with the deemer clause, should be adopted. As a compromise, "some of the staff" suggested that the language be incorporated, but only for a limited time subject to subsequent study. 3 Legislative History of the Employee Retirement Income Security Act of 1974, at 5283.

The conference bill combined these versions and recommendations in several ways. First, it adopted the current broad preemption provision without reference to specific core concerns of ERISA. Senator Javits explained that the change sprang from the concern that the more specific formulation "raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation," and a desire to err on the side of Federal uniformity. 120 Cong.Rec. 29,942, *reprinted in* 3 Legislative History of the Employee Retirement Income Security Act of 1974, at 4770. Second, the conference version retained the general savings language found in both the Senate and House bills. Finally, the conference committee decided to retain the deemer provision without any time limit but with a mandate for a later congressional study of the effects of Federal preemption.[5] 29 U.S.C. § 1222(a)(5).

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[5] The study that resulted, part of the 1977 Activity Report of the House Committee on Education and Labor, suggests an opposite interpretation of the deemer clause. According to the report:

> the "deemed" language was utilized to create an irrebuttable presumption that these plans are not insurance, trust companies, etc., for purposes of state regulation. As a drafting technique the "deemed" is used in section 514(b) not to *bar* the use of a legal fiction by the states but to *create* what may amount to a legal fiction in a given circumstance. The irrebuttable presumption would not be overcome even if an employee benefit plan engages in activities which

(Continued on following page)

The net effect of these changes reinforces the view that Congress intended the deemer clause to protect core ERISA concerns within the context of the insurance regulation exception to preemption. The "purporting" language, present at the creation and previously dealt with, suggests that such concerns arose as early as H.R. 12,906. More important, the retention of the deemer clause in the face of the expanded preemption clause indicates that the deemer clause in effect was meant to do the more narrow, specified work which the original version of the preemption clause was meant to do. Read in this way the legislative history and the three clauses make sense: first, the preemption clause preempts nearly any state law relating to employee benefit plans; second, the savings clause carves out the narrow but sizable exception of state laws regulating insurance; and finally, the deemer clause guards against any insurance regulation that infringes on such ERISA areas as reporting, disclosure, and nonforfeitability.

(Continued from previous page)

> bring it within the insurance, trust, or securities activities generally regulated by a state.

Subcomm. on Labor Standards, House Comm. on Educ. & Labor, ERISA Oversight Report of the Pension Task Force 10 (1977) (emphasis in original).

As the Court of Appeals for the Sixth Circuit pointed out, however, a "*post hoc* explanation . . . is entitled to little weight when it conflicts with a reasonable interpretation of statutory text and prior legislative history." *Northern Group Services*, 833 F.2d at 92 (citing *Consumer Product Safety Comm'n v. GTE Sylvania, Inc.*, 447 U.S. 102, 117-18 & n. 13, 100 S.Ct. 2051, 2061 & n. 13, 64 L.Ed.2d 766 (1980)).

Remarks of Senator Javits support this reading. Although not an exclusive list, all the examples of state law that the senator considered subject to preemption dealt with matters central to ERISA, of the type enumerated in the original preemption clause:

> In view of Federal preemption, State laws compelling disclosure from private welfare or pension plans, imposing fiduciary requirements on such plans, imposing criminal penalties on failure to contribute to plans – unless a criminal statute of general application – establishing State termination insurance programs, et cetera, will be superseded.

120 Cong.Rec. 29,942, *reprinted in* 3 Legislative History of the Employee Retirement Income Security Act of 1974, at 4771. Any reading other than one confined to the central aspects of ERISA would either have the deemer clause swallow the savings clause or read into the statute other distinctions that are not there.

The latter course is that followed by the *Pacyga* court and urged by FMC. In their view the deemer clause incorporates a bright line distinction between employee benefit plans that purchase insurance and those, like FMC's, which are self-insured. Plans that purchase insurance are subject to state regulation regardless of the deemer clause. Self-insured plans purportedly are not. *See Pacyga*, 801 F.2d at 1161.

The principal, if not sole, basis for this distinction is Supreme Court dicta. In *Metropolitan Life*, the Court upheld a Massachusetts law mandating that certain benefits be included in certain health plans. 471 U.S. 724, 105 S.Ct. 2380. The majority, reasoning that the state law

"regulated insurance" within the meaning of the savings clause, rejected the appellant's argument that the clause covered only direct regulation of traditional insurance activities. Apparently since the health plans at issue could not be considered ERISA employee benefit plans, the appellant did not assert an alternative deemer clause argument. The Court nonetheless stated:

> We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter.

Metropolitan Life, 471 U.S. at 747, 105 S.Ct. at 2393. For support the Court cited neither statutory text nor legislative history. Instead, relying on vague language in Congress' *post hoc* study the Court opined, in a footnote:

> A 1977 Activity Report of the House Committee on Education and Labor recognized the difference in treatment between insured and non-insured plans:
>
> > "To the extent that [certain programs selling insurance policies] fail to meet the definition of an 'employee benefit plan' [subject to the "deemer clause"], state regulation of them is not preempted by section 514, even though such state action is barred with respect to the plans which purchase these 'products.' " H.R. Rep. No. 94-1785, p. 48. A bill to amend the saving clause to specify that mandated-benefit laws are preempted by ERISA was reported to the Senate in 1981 but was not acted upon.

Metropolitan Life, 471 U.S. at 747 n. 25, 105 S.Ct. at 2393 n. 25.

Both the *Pacyga* court and FMC rely almost entirely on the foregoing dicta. In *Pacyga,* the court held that ERISA preempted Arizona antisubrogation law with regard to self-insured employee benefit plans. The court reasoned that such plans fell within the protection of the deemer clause on the basis of the distinction set forth in *Metropolitan Life. Pacyga,* 801 F.2d at 1161-62. The *Pacyga* opinion's terse treatment lacks any reference to statutory text, structure, or history.[6] It simply points to the formal distinction made in the *Metropolitan Life* footnote. Importation of that formal distinction to a different content is not proper in the face of direct consideration of congressional intent. Nor, as the *Northern Group Services* opinion has pointed out, need there necessarily be a conflict. The distinction between insured and self-insured plans does not disappear. Rather, under *Metropolitan Life* insured plans would *per se* survive the deemer clause, while self-insured plans would merely be considered on a case-by-case basis as to whether the state regulation involved

[6] Several other decisions have likewise imported the *Metropolitan Life* dicta, but the cases are distinguishable. *See Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987); *Shiffler v. Equitable Life Assurance Soc'y,* 838 F.2d 78 (3d Cir.1988). None of these cases dealt with the history or purpose of the deemer clause. The reason they did not, moreover, was that the claims brought forward fell prey not to the deemer clause, but directly to the preemption clause because the state laws involved did not "regulate insurance" under the savings provision. *See, e.g., Pilot Life,* 481 U.S. at 57 & n. 4, 107 S.Ct. at 1558 & n. 4; *Shiffler,* 838 F.2d at 81-82.

affects a central concern of ERISA. *Northern Group Services,* 833 F.2d at 94-95.

In light of the available interpretive materials the proper inquiry under the deemer clause is whether the state insurance regulation intentionally or unintentionally addresses a core type of ERISA matter which Congress sought to protect by the preemption provision. The court, reviewing a state insurance law, should inquire whether that law conflicts with any substitute mandate in ERISA. The parties and the amicus have suggested no such conflict. Thus the savings clause applies and the deemer clause does not.

III.

We have rejected FMC's contention that the antisubrogation provision in the Pennsylvania Financial Responsibility Law is inapplicable and its contention that if that provision applies it is preempted. The judgment appealed from will therefore be affirmed.

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 89-3226

FMC CORPORATION,
Appellant

v.

CYNTHIA ANN HOLLIDAY

SUR PETITION FOR REHEARING

Present: GIBBONS, *Chief Judge*, HIGGINBOTHAM, SLOVITER, BECKER, STAPLETON, MANSMANN, GREENBERG, HUTCHINSON, SCIRICA, COWEN and NYGAARD, *Circuit Judges*, and WOLIN, *District Judge**

The petition for rehearing filed by Appellant in the above entitled case having been submitted to the judges who participated in the decision of this court and to all the other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the court in banc, the petition for rehearing is denied.

*District Judge Alfred M. Wolin as to panel rehearing only.

By the Court,

/s/ John J. Gibbons
Chief Judge

DATED: October 5, 1989

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

FMC CORPORATION, a corporation, Plaintiff, vs. CYNTHIA ANN HOLLIDAY, an individual, Defendant.	Civil Action No. 88-1098

MEMORANDUM OPINION

BLOCH, District J.

Plaintiff and defendant having agreed that the material facts of this action are uncontroverted, this matter is before the Court on cross-motions for summary judgment. The material facts are as follows.

Defendant Cynthia Ann Holliday (Holliday) was seriously injured in an automobile accident in Indiana County, Pennsylvania, on January 16, 1987, when she was 15 years old. She required extensive medical treatment, costing in excess of $178,000.

At all relevant times, Holliday's father was an employee of plaintiff FMC Corporation (FMC). As such, he subscribed to the FMC Salaried Health Care Plan (the Plan), a self-insured employee welfare benefit plan. Pursuant to the Plan, FMC paid a substantial amount in medical benefits toward Holliday's treatment.

The Plan contained a coordination of benefits provision, pursuant to which it coordinated its benefits with

those of other medical plans and "no-fault" auto insurance providing medical coverage. Thus, FMC did not pay any benefits until certain insurers, such as the Holliday's automobile insurance company, had paid the maximum amount that they would pay.

In addition, the Plan summary provides:

> The FMC self insured benefit program is automatically assigned the right of action against third parties in any situation in which benefits are paid to employees or their dependents. If you bring a liability claim against any third party, benefits payable under this Plan must be included in the claim, and when the claim is settled you must reimburse the Plan for the benefits provided. You are obligated to avoid doing anything which would prejudice the Plan's rights of reimbursement, and you are required to sign and deliver documents to evidence or secure those rights. Unless you sign the Company's "third-party reimbursement form," the Claims Administrator will not process any claim where there is possible liability on behalf of a third party.

(Plan summary, at 49). Gerald Holliday, defendant's father, had signed such a third-party reimbursement form.

On April 20, 1987, Gerald Holliday, as parent and natural guardian of the defendant, commenced a negligence action in the Court of Common Pleas of Indiana County, Pennsylvania, against the driver of the vehicle in which defendant was a passenger at the time of the accident. FMC has notified defendant that it intends to exercise its subrogation rights with respect to any amounts obtained as a result of this lawsuit. Defendant

Holliday contends that §1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law of 1984 (the Pennsylvania law), 75 Pa.C.S.A. §1720, prohibits such subrogation. FMC argues that the Employee Income Retirement Security Act (ERISA) preempts the Pennsylvania law.

This Court may grant summary judgment "if the pleadings, depositions, answers to interrogatories and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). The parties in this case have agreed that there is no genuine issue as to any material fact. This Court holds that the defendant is entitled to judgment as a matter of law.

I. The Pennsylvania law applies to the Plan

Initially, of course, this Court must determine whether the Pennsylvania law would apply to the Plan at all. If §1720 would not prohibit FMC from obtaining subrogation, then this Court need not decide whether ERISA preempts that section. There would be no applicable Pennsylvania law which might be preempted.

Section 1720 of the Pennsylvania law, 75 Pa.C.S.A. §1720, provides:

> In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits in lieu thereof paid or payable under section 1719 (relating to coordination of benefits).

FMC clearly does not provide the required benefits or motor vehicle insurance referred to in §§1711, 1712 or 1715 of the Pennsylvania law, 75 Pa.C.S.A. §§1711, 1712, 1715. It does, however, provide the benefits referred to in §1719. This section provides:

> (a) *General rule.* – Except for workers' compensation, a policy of insurance issued or delivered pursuant to this subchapter shall be primary. Any program, group contract or other arrangement for payment of benefits . . . shall be construed to contain a provision that all benefits provided therein shall be in excess of and not in duplication of any valid and collectible first party benefits provided in section 1711, 1712 or 1715 or workers' compensation.
>
> (b) *Definition.* – As used in this section the term "program, group contract or other arrangement" includes, *but is not limited to,* benefits payable by a hospital plan corporation or a professional health service corporation. . . .

75 Pa.C.S.A. §1719 (emphasis added).

FMC contends that it is not a "program, group contract or other arrangement" under §1719 for two reasons. First, FMC argues that, because this section specifically lists certain types or corporations incorporated to provide health care benefits or services, only those "programs, group contracts or other arrangements" come within the section. To accept this reasoning would be to ignore the express language of the statute providing that those types of corporations are not the only types constituting a "program, group contract or other arrangement" under

§1719. The statute clearly states that the term "programs, group contracts or other arrangements" is not limited to the listed corporations.

Second, FMC contends that a comparison of §1720 to the subrogation provision of the prior Pennsylvania No-Fault Motor Vehicle Insurance Act (the No-Fault Act) indicates that the Pennsylvania legislature did not intend to prohibit subrogation on the part of entities such as the Plan. FMC notes that §111(a)(4) of the No-Fault Act provided that "[i]n no event shall *any entity* providing benefits other than no-fault benefits . . . have any right of subrogation with respect to said benefits." 40 P.S. §111(a)(4) (emphasis added). FMC claims that, by changing the description of those prohibited subrogation rights from "any entity" to "program, group contract or other arrangement," the legislature must have intended to exclude plans such as the one at issue from being affected by the subrogation provision.

It is true that when words of a later statute differ from those of a previous one on the same or a related subject, it is presumed that the legislature intended them to have a different meaning. *Klein v. Republic Steel Corp.*, 435 F.2d 762, 765-66 (3d Cir. 1970). It is not true, however, that this Court may assume that the different meaning intended is that which the plaintiff advocates. FMC attempts to convince this Court that the Court should make this assumption because, in another portion of the Pennsylvania law, the Pennsylvania legislature has afforded a right of subrogation to Assigned Claims Plans. 75 Pa.C.S.A. §1756.

Assigned Claims Plans are plans designed to provide medical benefits to, *inter alia*, people not entitled to receive first-party benefits under the Pennsylvania law. 75 Pa.C.S.A. §1752. FMC argues that the Pennsylvania legislature could not have intended to allow Assigned Claims Plans a right of subrogation but prohibit subrogation on the part of employee welfare benefit plans providing benefits in addition to first-party benefits.

It is entirely possible that this is exactly what the Pennsylvania legislature intended to do. Motor vehicle insurance companies are required by law to establish Assigned Claims Plans. Those who would recover under such plans may not be otherwise paying insurance premiums for their coverage. Furthermore, in these instances, the Assigned Claims Plans pay benefits instead of first-party benefits, because the recipients are not eligible to receive first-party benefits. In such an instance, the legislature may have intended to allow Assigned Claims Plans some right of subrogation while other entities, providing benefits in addition to first-party benefits, are not able to obtain subrogation. Without more convincing evidence that the Pennsylvania legislature did not intend §1720 to apply to employee welfare benefit plans, this Court will not read out of the statute the language which explicitly indicates that the term "program, group contract or other arrangement" includes more than certain types of health care or health service corporations.

Moreover, as defendant points out, FMC has availed itself of the benefits of the Pennsylvania law's "coordination of benefits" provision as set forth at §1719. FMC required that the Hollidays' motor vehicle insurer pay up to its policy limits before FMC would provide benefits.

Thus, by its own actions, FMC has indicated that it is the type of entity referred to in §1719.

Thus, if it is not preempted, §1720 of the Pennsylvania law would prohibit FMC's exercise of subrogation rights in any amount Holliday recovered in the case in the Indiana County court.

II. ERISA'S preemption provisions

Section 1514(a) (sic) of ERISA, 29 U.S.C. §1144(a), provides generally that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." There is one exception to this broad preemption provision, contained in a "savings clause," providing:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities.

29 U.S.C. § 1144(b)(2)(A).

The savings clause does not automatically exempt all state laws regulating insurance from preemption, however, because it is modified by the so-called "deemer clause," which provides:

> Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. §1144(b)(2)(B).

Thus, in order to determine whether ERISA preempts the Pennsylvania law in this case, this Court must first determine whether the Pennsylvania law relates to an employee benefit plan. Next, this Court must determine whether, even if the Pennsylvania law relates to an employee benefit plan, it is exempted from preemption by the savings clause because it regulates insurance. Finally, if the answers to the first two inquiries are affirmative, this Court must determine whether the "deemer clause" nevertheless operates to prevent the Pennsylvania law from being saved from preemption. *See Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 45 (1987).

A. The Pennsylvania law "relates to" the Plan

A state law relates to an employee benefit plan if it has a connection with or reference to such a plan. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983). Preemption is not limited to state laws specifically designed to affect employee benefit plans. *Id.* at 98. Instead, ERISA preempts even common-law causes of action which seek remedies for improper processing of a claim for benefits under an ERISA plan. *Pilot Life*, 481 U.S. at 48.

FMC argues that §1720 of the Pennsylvania law does not "relate to" the Plan because the Pennsylvania legislature did not intend this provision to apply to employee welfare benefit plans such as the plan at issue. This

argument is without merit. This Court has already determined that the Pennsylvania law does indeed apply to the Plan.

Furthermore, the Pennsylvania law need not have been specifically designed to affect employee benefit plans to relate to such plans. *Shaw*, 463 U.S. at 98. The phrase "relate to" has been given the broadest commonsense meaning. *Shiffler v. Equitable Life Assurance Society of the United States*, 838 F.2d 78, 81 (3d Cir. 1988). Therefore, as long as a lawsuit would have a connection with an employee benefit plan, it relates to it so that any state causes of action upon which the suit is based are preempted.

Finally, this Court notes that it would be anomalous for FMC to assert that the law does not relate to the Plan when FMC is the party asserting preemption. ERISA preempts state law only if that law relates to an employee benefit plan. Thus, this Court must assume that FMC's statement that it will only "assume *arguendo*" that the Pennsylvania law relates to the Plan was inserted into FMC's brief merely in order to preserve FMC's argument that the law does not apply to the Plan in the first place.

B. The Pennsylvania law regulates insurance

To determine whether a state law regulates insurance, this Court must examine the law both to determine whether it comports with a common-sense understanding of the phrase "regulates insurance" and to ascertain whether it affects the business of insurance as that business is defined in the McCarran-Ferguson Act. *See Pilot*

Life 481 U.S. at 50-51; *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 743 (1985). No one factor is dispositive; rather, each is instructive. *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 129 (1982); *Insurance Board Under Social Insurance Plan of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408, 411 (3d Cir. 1987); *United Food and Commercial Workers v. Pacyga*, 801 F.2d 1157, 1161 (9th Cir. 1986).

In this case, the parties have agreed that this law regulates insurance. Thus, the Pennsylvania law is saved from preemption by 29 U.S.C. §1144(b)(2)(A), unless the "deemer clause" prohibits the law from being saved from preemption.

C. The deemer clause does not operate to bring the Pennsylvania law back within the scope of ERISA preemption

As previously noted, the deemer clause provides that state laws purporting to regulate insurance may not directly regulate employee benefit plans by "deeming" them to be insurance companies for the purposes of such laws. *Pilot Life*, 481 U.S. at 45. The Plan at issue is a self-insured plan. That is, FMC does not provide benefits for its employees by taking out a group insurance policy with an insurance company. Instead, FMC provides the funds needed to pay any medical benefits due under the Plan out of its own assets.

FMC contends that to apply the Pennsylvania law to a self-insured plan, one must first "deem" the plan to be an insurance company. Thus, such application of the Pennsylvania law would violate the deemer clause. As a

result, the Pennsylvania law as it applies to self-insured plans is preempted, even though it regulates insurance.

Following this reasoning, a number of courts have held that certain state laws regulating insurance are nonetheless preempted as they apply to self-insured plans. *See, e.g., Pacyga*, 801 F.2d 1157 (Arizona anti-subrogation law preempted as applied to self-insured plans); *Powell v. Chesapeake and Potomac Telephone Co.*, 780 F.2d 419 (4th Cir.), *cert. denied*, 476 U.S. 1170 (1986) (common-law claims relating to mishandling of benefits requests preempted as applied to self-insured plan); *Children's Hospital v. Whitcomb*, 778 F.2d 239 (5th Cir. 1985) (Louisiana anti-discrimination benefits statute preempted as applied to self-insured plans); *Kilmer v. Central Counties Bank*, 623 F. Supp. 994 (W.D. Pa. 1985) (portion of No-Fault Act permitting double recovery of benefits preempted as applied to self-insured plans).

Application of this reasoning would result in certain employee benefit plans being free from state laws regulating insurance merely because they chose to self-insure. Indeed, the Supreme Court itself has stated in *dicta* that, through the deemer clause, Congress has distinguished between insured and self-insured plans in such a way. "By doing so we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter." *Metropolitan Life*, 471 U.S. at 747 (footnote omitted). *See also Board of Trustees of Montana Teamsters Employers v. Coyne*, 628 F. Supp. 561, 564 (D. Mont. 1986).

On the contrary, however, it is possible to read the three interlocking preemption provisions of ERISA – the

preemption section, the savings clause and the deemer clause – to give life to the deemer clause yet not presume that Congress intended to make an illogical distinction between insured and self-insured plans. In *Northern Group Services, Inc. v. Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir.), *cert. denied*, 108 S.Ct. 1754 (1988), the Sixth Circuit Court of Appeals held that the deemer clause does not automatically immunize self-insured employee benefit plans from state laws regulating insurance. 833 F.2d at 91. In *Northern Group Services*, certain employee benefit plans, some insured by others and some self-insured, attempted to make no-fault automobile insurers primarily liable and their own plans secondarily liable for benefits. When the no-fault automobile insurers objected, citing Michigan insurance law, the plans argued that the Michigan law was preempted, by virtue of the deemer clause in the case of the self-insured plans.

The Court noted that Congress has expressly declared in two different ERISA subsections that ERISA does not preempt state laws regulating insurance. *Id.; see* 29 U.S.C. §§1144(b)(2)(A); 1144(d). It stated:

> In the face of this redoubled statutory preservation of the principle favoring state regulation of insurance, it appears contrary to the overall legislative purpose to read the deemer clause broadly to bar all state regulation of self-insured plans. In this area of traditional state regulation, "the presumption is against preemption."

833 F.2d at 92, *quoting Metropolitan Life*, 471 U.S. at 741.

The Court in *Northern Group Services* noted that the legislative history of the deemer clause was ambiguous.

In fact, certain portions of the legislative history indicate that Congress' central concern in adopting the ERISA preemption scheme was "to avoid intentional – and perhaps pretextual – attempts by states to restrict the discretion of ERISA plans to engage in practices that otherwise would be permitted by federal law." 833 F.2d at 93. In *Northern Group Services*, as in this case, the parties did not argue that the state was, intentionally or by pretext, attempting to focus specifically on ERISA plans in the statutes at issue.

The Court in *Northern Group Services* held:

> In the absence of a showing of state purpose specifically to regulate the content of welfare benefits provided by ERISA, the effect of the deemer clause should be assessed by a balancing of the interests in federal uniformity against those of state primacy in the regulation of insurance.

Id.

The Court in *Northern Group Services* ruled that exempting self-insurers from the Michigan law requiring that insurers coordinate benefits so that no-fault automobile insurers were secondarily liable would disrupt the state's ability to administer a uniform scheme of coordination of benefits. Such disruption would frustrate the state's goal of cost containment, create unpredictability and possibly undermine the financial stability of no-fault insurers. Similarly, in this case, exempting self-insurers from the Pennsylvania law prohibiting subrogation would disrupt the state's ability to administer a generally uniform scheme of prohibiting subrogation, except in certain specific instances in which Assigned Claims Plans

are required by law to provide benefits to those who would not otherwise receive them. In those incidents, as a matter of equity, the state has chosen to permit subrogation. Otherwise, the state's uniform goal of prohibiting subrogation remains intact.

Furthermore, by holding that §1720 of the Pennsylvania law as applied to self-insured plans comes within the deemer clause and is thus preempted by ERISA, this Court would be permitting plans to ensure that they could obtain subrogation merely by deciding to self-insure.

Weighing this injury to the state scheme against the federal interest in uniform administration of ERISA plans, it is clear that the injury to the state scheme far outweighs any federal interest in developing a "federal common law" of subrogation rights of self-insured ERISA plans. This area of insurance law, like the area of coordination of benefits, has been developed by each state over a period of years. *See* 833 F.2d at 93-94. Injury to the state scheme would be especially great when federal law would encroach upon state law in an area in which states enjoy "general authority and autonomy" – insurance regulation. *Id.*

As noted in *Northern Group Services*, this approach does not necessarily contravene the *Metropolitan Life dicta* quoted earlier in this opinion. The rule enunciated by the Court in *Northern Group Services* and followed by this Court today preserves a distinction between plans insured by others and those which are self-insured. Insured plans are *per se* open to indirect regulation. Self-insured plans are subject to state regulation only when no

independent federal interest in national uniformity, outweighing the state interest in insurance regulation, exists to inform and guide the creation of a federal common law in the area at issue. *Id.* at 95.

Thus, under this reasoning, because no such independent federal interest exists, §1720 of the Pennsylvania law as applied to self-insured plans such as the one at issue is not excluded from the savings clause by the deemer clause. ERISA does not preempt §1720 because of the savings clause, so the terms of the Plan do not govern the subrogation issue. FMC may not assert subrogation rights to any recovery Holliday obtains in the suit pending before the Court of Common Pleas of Indiana County.

An appropriate Order will be issued.

Date: 3/14/89

/s/ Alan N. Bloch
United States District Judge

cc: Counsel of record.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

FMC CORPORATION, a corporation, Plaintiff,	)	Civil Action No. 88-1098
vs.	)	
CYNTHIA ANN HOLLIDAY, an individual, Defendant.	)	

JUDGMENT ORDER

AND NOW, this 14th day of March, 1989, upon consideration of Plaintiff's Motion for Summary Judgment filed in the above captioned matter on December 2, 1988, IT IS HEREBY ORDERED that said Motion is DENIED.

AND, further, upon consideration of Defendant's Motion for Summary Judgment filed in the above captioned matter on December 5, 1988, IT IS HEREBY ORDERED that said Motion is GRANTED.

/s/ Alan N. Bloch
United States District Judge

cc: Charles Kelly, Esquire
1500 Oliver Building, Pittsburgh, PA 15222

Thomas Johnson, Esquire
406 Indiana Theatre Building, Indiana, PA 15701

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

FMC CORP. EMPLOYEE WELFARE BENEFITS PLAN COMMITTEE, et al.,	)	C-88-3092-FMS
Plaintiff(s),	)	*ORDER GRANTING PARTIAL SUMMARY JUDGMENT*
v.	)	
THE GOOD SAMARITAN HOSPITAL OF THE SANTA CLARA VALLEY,	)	(Filed December 5, 1988)
Defendant(s).	)	

This is a motion for summary declaratory judgment on a part of the plaintiffs' claim. Plaintiffs request the Court to declare that they have a right to subrogate their claims to those of a third party against the defendant. The Court heard argument on the plaintiffs' motion regularly on November 16, 1988 at 10:00 a.m.

Summary judgment is proper only when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *Sankovitch v. Life Ins. Co. of No. America*, 638 F.2d 136, 138 (9th Cir. 1981). In deciding a motion for summary judgment, the Court draws all inferences of fact in favor of the party opposing the motion. *Id.; Bieghler v. Kleppe*, 633 F.2d 531 (9th Cir. 1980). Defendant, in opposing plaintiffs' motion, has submitted no sworn affidavits or declarations. Nor has defendant made a motion under Fed. R. Civ. P. 56(f) indicating that it has not yet had the opportunity to gather the facts necessary to effectively controvert the facts asserted by the movant. Defendant

does attempt to catalogue a number of "triable issues of fact" in its brief in opposition to plaintiffs' motion. But it is well established that assertions made in legal memoranda and at oral argument are not evidence and cannot create issues of fact. *Flaherty v. Warehouseman Local 334*, 574 F.2d 484 (9th Cir. 1978). Thus, the Court finds no genuine issues of material fact as to those facts asserted in plaintiffs' declarations. Nevertheless, even where no evidence is presented in opposition to the motion, summary judgment should not be granted if the evidence in support of the motion is insufficient to entitle the movant to judgment as a matter of law. *Hoover v. Switlik Parachute Co.*, 663 F.2d 964, 967 (9th Cir. 1981).

FACTUAL BACKGROUND

Plaintiffs are an employee welfare benefits plan (the "plan") and the committee entrusted with administering the plan. Defendant is in the business of providing health care. One of the employees covered by the plan, a Mrs. Lo Nero, has sued the defendant in state court for medical malpractice (the "state court action"). Mrs. Lo Nero is not a party to this action. In her state court action, Mrs. Lo Nero is seeking her medical expenses, among other things. The plan alleges in this action that it has paid at least some of the medical expenses that Mrs. Lo Nero is seeking to recover in the state court action. In Count I of the Complaint in this action, the plan seeks a declaratory judgment that it has a right of subrogation to recover what it has allegedly paid out on behalf of Mrs. Lo Nero. The remainder of the Complaint contains counts for the actual subrogation action. The only count at issue on this motion is Count I for declaratory judgment.

DISCUSSION

The parties agree that the issue of plaintiffs' right of subrogation turns on two questions: 1) whether California Civil Code Section 3333.1, which prohibits subrogation for collateral source payments in medical malpractice actions, is preempted by the Employee Retirement Income Security act of 1974, as amended ("ERISA"), 29 U.S.C. 1001 et seq. and 2) whether the plan, at the relevant times, contained a right of subrogation at all.

Preemption

Section 3333.1 provides in relevant part that

> (b) No source of collateral benefits introduced [as evidence by a medical malpractice plaintiff] shall recover any amount against the plaintiff nor shall it be subrogated to the rights of the plaintiff against a defendant.

Neither party disputes that the purpose and effect of this statute is to overturn the collateral source rule as it applies to medical malpractice actions and to prohibit subrogation in such actions. *Barme v. Wood*, 37 Cal.3d 174 (1984).

The ERISA statute is broadly preemptive of state laws. If a state law "relates to" employee welfare benefit plans, ERISA preempts it. 29 U.S.C. 1144(a); *Pilot Life Ins. Co. v. Dedeaux*, 107 S. Ct. 1549, 1553 (1987). Congress, however, did not intend the preemptive provisions of ERISA to divest the states of their power to regulate the insurance industry. "[F]ederal laws should not be construed to supersede state laws 'regulating the business of insurance.' " *Metropolitan Life Ins. Co. v. Massachusetts*, 471

U.S. 724, 736 (1984); 15 U.S.C. 1012(b). Congress expressly "saved" from ERISA preemption any state laws "which regulate insurance." 29 U.S.C. 1144(b) (the "savings clause"). Thus, if Section 3333.1 is a law regulating insurance, then it is not preempted by ERISA.

More precisely, if the a (sic) state law comes within the savings clause, it is not preempted as against insurance companies. Although Congress was careful to leave undisturbed by the ERISA legislation the reservation to the states of the task of insurance regulation, Congress was also careful to distinguish between insurance companies and ERISA plans. Congress recognized that the similarities between them would result in their being state laws that affect both. In order to keep legitimate state insurance regulations from encroaching on the exclusively federal domain of ERISA plan regulation, Congress qualified the savings clause with the "deemer clause" which provides that

> [n]either an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . . .

29 U.S.C. 1144(b)(2)(B). Under the deemer clause, if a state law regulating the business of insurance has application on its face to ERISA plans as well, the state law is preempted insofar as it applies to the ERISA plans. *Metropolitan Life*, 471 U.S. at 747; *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157, 1160-62 (9th Cir. 1986).

Thus, the preemption analysis in this case runs as follows. If Section 3333.1 relates to the plaintiff plans, it is preempted by the ERISA statute. If, however, Section 3333.1 is a state law regulating the business of insurance, it is "saved" from preemption and is fully operative. But, if the plaintiff plans are not insurance companies actually providing insurance contracts but rather must be "deemed" to be insurance companies by Section 3333.1 in order to come within that law's purview, then the plans are protected by the deemer clause from the operation of Section 3333.1. *See Pacyga,* 801 F.2d at 1159-62.

Defendant concedes that Section 3333.1 "relates to" the plans and is thus subject to preemption. Def. Opp. at 6. The next question is whether Section 3333.1 regulates the business of insurance. Defendant contends that it does. Plaintiff asserts that it does not. In *Pilot Life,* the Supreme Court stated that in order to regulate insurance, a statute "must not just have an impact on the insurance industry, but be directed to that industry." 96 L.Ed.2d at 96. It is true that Section 3333.1 on its face makes no mention of the insurance industry or any of its elements and that the law has application outside the insurance industry. On the other hand, Section 3333.1 is part of the Medical Injury Compensation Reform Act of 1975 (MICRA), the comprehensive effort of the California legislature to address what it saw as catastrophic skyrocketing in medical malpractice insurance premiums. The question of whether Section 3333.1 regulates insurance within the meaning of the ERISA savings clause is a close one.

Assuming, without deciding, in the defendant's favor that Section 3333.1 does regulate the insurance industry

and therefore does come within the protection of the ERISA savings clause, the question becomes whether ERISA's deemer clause protects the plaintiffs from the operation of Section 3333.1.

In attempting to understand the operation of the deemer clause, the *Metropolitan Life* and *Pacyga* cases are most instructive. In *Metropolitan Life,* the Court distinguished between insured and uninsured employee welfare benefits plans. "Plans may self-insure or they may purchase insurance for their participants. Plans that purchase insurance – so-called 'insured plans' – are directly affected by state laws that regulate the insurance industry." 471 U.S. at 732. The Court held that insured plans may be regulated by the states because the deemer clause need not come into play since insured plans do not have to be "deemed" anything in order to come under state insurance statutes. State insurance statutes simply end up indirectly regulating insured plans by regulating the insurance those plans purchase. Uninsured plans are different. They would not be indirectly regulated through insurance regulation and would have to be "deemed" part of the insurance industry in order to come within legitimate state insurance regulation. This is precisely what the deemer clause prohibits. "We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." *Id.* at 747; *see also Pacyga,* 801 F.2d at 1161.

The plan at issue here is a self-funded uninsured plan. Decl. of Morrissey in Support of Motion at 2-3. Although there is no evidence submitted by the plaintiffs to the effect that the plan carries no insurance at all or

that the plan provides no other services for which it is insured, these matters would still not take the plan out of the protection of the deemer clause. *Pacyga*, 801 F.2d at 1161-62; *Moore v. Provident Life and Accident Ins. Co.*, 786 F.2d 922 (9th Cir. 1986).

In sum, Section 3333.1 is preempted by ERISA at least insofar as it would have applied to the plaintiffs here. The defendant cannot avail itself of the operation of Section 3333.1 to avoid plaintiffs' right to subrogate.

Contractual Right of Subrogation

Plaintiffs assert that if Section 3333.1 is preempted and therefore not an obstacle to subrogation, the plaintiffs have ā contractual right of subrogation. Plaintiffs assert that the document setting forth the terms of the plan at issue is a valid and enforceable contract vesting in the plan itself rights of subrogation in two situations: 1) where a beneficiary recovers from a third party the value of benefits received from the plan, the plan may be reimbursed for those benefits, or 2) where a beneficiary does not, or cannot, assert its claim directly against a culpable third party, the plan may assert the substantive right of the beneficiary. Decl. of Morrissey in Support of Plaintiffs' Motion at 3.

In opposition, defendant points out that the plan's terms, as they existed in 1986, did not include the express right of subrogation. The plan today has an express subrogation term written into the plan in 1987. Decl. of

Morrissey at 3. In 1986, when the claimed right of subrogation at issue here would have arisen, the plan had no such express language.

Plaintiffs claim that language in the 1986 plan informing beneficiaries that they "will never receive more than 100% of the medical expenses incurred" was always interpreted by the plan's trustees to give the plan the rights of subrogation enumerated above and that the 1987 amendment to the plan making express these rights of subrogation were merely cosmetic and did not expand in any way the plan's subrogation rights. Decl. of Morrissey at 3. Defendant has submitted no evidence that such was not the case. Furthermore, it is well settled that the interpretation of a plan's provisions by its administrator will not be overturned absent arbitrary, capricious or legally erroneous conduct. *Nevill v. Shell Oil Co.*, 835 F.2d 209 (9th Cir. 1987). On the record before it, this Court rules that, Section 3333.1 being inapplicable to the parties herein, plaintiffs' (sic) possess the right to subrogate in the manner alleged in Count I of the Complaint in this action and therefore, Plaintiffs' Motion For Partial Summary Judgment as to Count I of the Complaint is hereby GRANTED.

SO ORDERED.

December 5, 1988
San Francisco, California

/s/ Fern M. Smith
FERN M. SMITH
United States District Judge